Exhibit 24

STATE FARM
P.O. BOX 2361

BLOOMINGTON IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID) X			1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22C440773
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX: M X F		4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other		7. INSURED'S ADDRESS (No., Street): SAME
	8. PATIENT STATUS: Single Married Other X; Employed Full-Time Student Part-Time Student		CITY / STATE; ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES / NO X		a INSURED'S DATE OF BIRTH MM DD YY / SEX: M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX: M F	b. AUTO ACCIDENT? YES X / NO / PLACE (State) MI		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / NO X		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO X If yes, return to and complete Item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 01 27 2011 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: JAMES BEALE DO	17a. / 17b. NPI 1316934409	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES / NO X $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 854.00 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.; 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05312011	05312011	11		70551		1	5400.00	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25 FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27 ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29 AMOUNT PAID	30 BALANCE DUE
300170094	X	2729460	X YES / NO	$ 5400.00	$ 0.00	$ 5400.00

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32 SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
VIVEK SEHGAL MD	THE IMAGING CTR	2485838922
SIGNED 06/01/2011 DATE	15670 SOUTHFIELD RD	MICHIGAN BIOTECH PRTNRS
	ALLEN PARK MI 481012513	30781 STEPHENSON HWY
	a.	MADISON HTS MI 48071-1618
		a 1821095472 b G2300170094

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Fold

22C440773

Bio-Magnetic
MRI/MRA Imaging Centers

Bio-Magnetic Resonance, Inc.
30781 Stephenson Highway
MADISON HEIGHTS, MI 48071
(248) 585-5115
FAX (248) 585 0234

EXAM DATE: *05/31/2011 11:33:19*

PATIENT NAME: [redacted]
PATIENT ID: *1707460*
LOCATION: THE IMAGING CENTER

SEX: *M*
DOB: [redacted]

The Imaging Center
15670 Southfield Road
ALLEN PARK, MI 48101
(313) 294-2897
FAX (313) 294 2915

REFERRING PHYSICIAN: DR. J. BEALE

EXAMINATION: BRAIN MRI WITH AND WITHOUT MAGNEVIST
FINAL REPORT

Bio-Magnetic Resonance, Inc.
25100 Kelly Road
ROSEVILLE, MI 48066
(586) 445-4900
FAX (586) 445-4902

CLINICAL HISTORY:

43 year old male with MVA and now complaining of frequent, intermittent, throbbing pain to temples. Dizziness, lightheadedness, and short term memory loss.

MR IMAGING PROTOCOL:

Multi-planar multi-sequences MR images were obtained of the brain. No similar previous studies are available for comparison at the present time.

MR FINDINGS:

Diffusion weighted images show no restrictive diffusion abnormality to suggest an acute stroke or bleed. The cortical volume is normal. The grey-white differentiation is normal.

Biomagnetic Imaging Center
960 River Centre Drive
PORT HURON, MI 48060
(810) 966-6523
FAX (810) 966-6056

No significant white matter abnormalities are seen.

T2 diffusion tensor imaging is normal.

The lateral ventricles are normal in size and symmetric bilaterally. The 3rd and 4th ventricles are midline. The rest of the subarachnoid system is within normal limits. Normal vascular flow voids are seen. The sella and parasellar regions are normal. The craniocervical junction is normal. The calvarium, skull base, and soft tissues of the scalp are normal. The visualized orbits are normal.

The Imaging Center
4447 Talmadge, Suite H
TOLEDO, OH 43623
(888) 674-8653
FAX (888) 674-8656

Inflammatory changes are seen in the frontal, bilateral ethmoid, and maxillary sinuses. The mastoid air cells are almost completely opacified bilaterally.

(888) MRI-TODAY
(674-8632)
www.biomagnet.com

Dictated: Sehgal, Vivek MD 06/01/2011 02:56 PM
Transcribed: Solomon, Peggie 06/01/2011 04:05 PM
Electronically signed: Sehgal, Vivek MD 06/01/2011 04:34 PM

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DOB: [redacted]

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FAX (248) 585 0234

IMPRESSION:

1. No significant intracranial abnormalities seen.
2. Sinus disease in the frontal, ethmoid, maxillary sinuses and bilateral mastoid inflammatory changes.

The Imaging Center
15670 Southfield Road
ALLEN PARK, MI 48101
(313) 294-2697
FAX (313) 294-2915

Thank you for your referral,

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